Ethnocultural Aspects of Posttraumatic Stress Disorder

Issues, Research, and Clinical Applications

EDITED BY

Anthony J. Marsella

Matthew J. Friedman

Ellen T. Gerrity

Raymond M. Scurfield

AMERICAN PSYCHOLOGICAL ASSOCIATION
WASHINGTON, DC

Copyright © 1996 by the American Psychological Association. All rights reserved. Except as permitted under the United States Copyright Act of 1976, no part of this publication may be reproduced or distributed in any form or by any means, or stored in a database or retrieval system, without the prior written permission of the publisher.

First printing February 1996
Second printing September 1996
Third printing August 1997

Published by
American Psychological Association
750 First Street, NE
Washington, DC 20002

Copies may be ordered from
American Psychological Association
Order Department
P.O. Box 92984
Washington, DC 20090-2984

In the UK and Europe, copies may be ordered from
American Psychological Association
3 Henrietta Street
Covent Garden, London
WC2E 8LU England

Typeset in Goudy by PRO-IMAGE Corporation, Techna-Type Div., York, PA

Printer: Port City Press, Baltimore, MD
Cover and Jacket Designer: Minker Design, Bethesda, MD
Jacket Illustrator: Stephanie Shieldhouse, Jacksonville, FL
Technical/Production Editor: Sarah J. Trembath

Library of Congress Cataloging-in-Publication Data
Ethnocultural aspects of posttraumatic stress disorder : issues, research, and clinical applications / edited by Anthony J. Marsella . . . [et al.].
p. cm.
Includes bibliographical references and index.
ISBN 1-55798-319-4 (acid-free paper)
1. Post-traumatic stress disorder—Cross-cultural studies. 2 Psychiatry, Transcultural. I. Marsella, Anthony J.
RC552.P67E83 1996
616.85'21—dc20 95-40252
CIP

British Library Cataloguing-in-Publication Data
A CIP record is available from the British Library.

Printed in the United States of America

17

A MULTICULTURAL DEVELOPMENTAL APPROACH FOR TREATING TRAUMA

FRED. D. GUSMAN, JUDITH STEWART, BRUCE HILEY YOUNG, SHERRY J. RINEY, FRANCIS R. ABUEG, and DUDLEY DAVID BLAKE

INTRODUCTION

The ability to treat trauma victims is enhanced when the clinician fully integrates an appreciation of cultural differences. This chapter draws upon decades of direct clinical experience with victims of a wide range of catastrophic stress including natural disaster, child abuse, sexual assault, and combat. To elucidate our approach, we begin with case examples drawn from (a) the Japanese American internment experience and (b) the Vietnam war. These extreme traumas of isolation, terror, and fear of death highlight the convergence of social, moral, and political issues in the minority experience of victimization.

The Case of "Pat"

Pat was 15 years old in 1942 when President Franklin D. Roosevelt signed the order for the internment of all Japanese Americans. Pat and his family were forced to move, and as a result, Pat and his family lost their home, their community's support, their friendships, and their sources of livelihood and recreation. As internees, their multicultural identity as Japanese Americans was instantaneously redefined as untrustworthy enemies of the state. Furthermore, they were viewed as

people who were somehow less than the German or Italian immigrants whose countries of national origin were equally at war with the United States but who were not interned. Common responses to the internment included feelings of betrayal, outrage, shame, and helplessness.

In addition, the adverse conditions of the internment camps worsened the violations of Pat's sense of self and dignity. Victimized by violence and lack of privacy, Pat recalls shifting from being socially active to increasingly withdrawn and apathetic. As his preinternment Japanese American identity was being destroyed, the resulting void left Pat an adolescent without an integrated identity. Perceiving himself as neither American, Japanese, nor Japanese American, Pat was left with the impossibility of finding or developing an acceptable identity in place, culture, and time. In retrospect, this formidable developmental task remained incomplete for the 15-year-old Pat, and a loss of self-cohesion ensued.

Fifty years later, when a flood destroyed much of Pat's home and personal possessions, like other flood victims, he showed the common signs of posttraumatic stress. In addition, as the federal application process to repair his home became increasingly complicated by bureaucratic procedures, Pat experienced overwhelming anxiety. The cognitions associated with his anxiety included suicidal ideation, helplessness, and the existential angst of questioning who he was and where he belonged. Unlike other victims who are commonly irritated by the application process, in Pat's case the governmental procedures precipitated a reactivation of the intense psychological sequelae of the internment: feelings of mistrust, shame, alienation, and a tenuous sense of identity.

Pat sought therapy, and although the therapeutic process is not complete, he has reported more manageable levels of anxiety, has overcome his apathy (completing the federal relief application process), and has begun to experience a positive sense of identity again as a Japanese American. The clinical regimen of exploring and affirming the affect associated with his traumatic experiences, combined with providing support for redeveloping his multicultural identity, appear to promote Pat's experience of greater self-cohesion.

The Case of "Clay"

Clay is an American Indian war veteran raised in San Francisco. During his military service, he was nicknamed *Chief* by his fellow squad members and, because of his ethnicity and appearance, was believed to have stereotypical American Indian traits (e.g., keen senses and an ability to track). Based on this assumption, he was selected to *walk point* (i.e., walk at the front of his squad when on patrol) and, wanting to be a team member, agreed to do so. He accepted the role of point man as a challenge and learned to do the job well without realizing the potential challenge to his identity issues. Clay struggled with con-

flicting feelings regarding the squad's assumptions of his abilities to sense and to track and his desire to take on the role as part of his American Indian identity.

While he was point man, there were no enemy encounters, thereby reinforcing his own and the squad's perceptions of his exceptional abilities. During a time when another squad member was in the point position, the squad walked into an ambush and experienced several casualties. Clay felt guilty and responsible for the encounter because he was not walking point at the time. Thereafter, he and the squad incurred numerous casualties from a series of catastrophic engagements with enemy units.

Following his discharge from the military, Clay returned to San Francisco where he eventually sought treatment for intrusive war memories, nightmares, and rage. His therapist learned that Clay was raised in an urban environment, with little exposure to traditional American Indian culture. The treatment process began with helping Clay to identify who he was prior to the military and combat, recognizing that he was an urban American Indian whose family was well assimilated into general society. Clay's parents encouraged him to view himself as a member of the larger society so that he might accomplish more in his life without the potential restrictions of his ethnicity. His military and combat experiences directly conflicted with those parentally instilled mainstream culture views because he was labeled *Chief* and was expected to have the special talents and abilities of a stereotypical American Indian. Clay accepted this label in direct opposition to stronger self-identification with his Americanized self.

The therapist assisted Clay in examining his life using a developmental perspective, identifying connections between events and his evolution into adulthood and evaluating pretrauma circumstances that helped shape his identity. In addition, Clay was able to experiment with an increasingly more complex cultural identity in the context of a war trauma group (with 8 members) as well as the larger community of patients in the center (more than 80 other war veteran patients). This process helped Clay to reorganize and begin to understand his beliefs, values, expectations, and fears at the time he entered the military and later when he was walking point in the bush. While reviewing the traumatic events, the therapist helped Clay to find new and positive meanings of the events (e.g., a greater appreciation for and connection with his heritage), providing a sense of control in his life and over his past.

THE ETHNOCULTURAL FACTOR IN PTSD

The population of the United States is multicultural. Each person in America is part of several cultures shaped by ethnic, religious, or political values; and exposure to metropolitan or rural, educational, or biotechno-

logical environments. In addition, each person in the United States has ancestors that have immigrated to America or, in the case of American Indians, has ancestry who were forced to live within a culture other than their own. Any one individual, therefore, may have a multicultural identity or several self-conceptualizations that may or may not form a unified, culturally coherent identity (Madsen, 1964). Mental health treatment provided to individuals diagnosed with PTSD should address the points of interaction between victims' multicultural identity and their traumatization (e.g., Marsella, Chemtob, & Hamada, 1990; Westermeyer, 1989; Young & Erickson, 1988, see also chapter 4, this volume).

Traditional acculturation and bicultural models (e.g., Berry, 1990; Gordon, 1964; Sue & Sue, 1990) assume that an individual moves toward the dominant culture and away from their culture of origin. Numerous important findings, especially in the area of immigrant adjustment, have emerged from this model. In contrast, the multicultural model proposed by Oetting and Beauvais (1990) suggests that a unidimensional description of race or ethnicity is not tenable in the study of the complexities of American culture. With immigration and blending of various ethnic origins, sole dominant identifications do not provide for an adequate understanding of mixed heritage. Indeed, for many Americans several independent identities with separate origins may coexist and may be maintained behaviorally and cognitively over time (Boehlein, 1987).

This multicultural perspective also is rooted in role theory and suggests that a person can hold simultaneously a number of ethnic identities, each composed of a dynamic network of attitudes and beliefs (Goode, 1960; Gove & Tudor, 1973; Pearlin, 1983; Sarbin, 1954). When one's primary ethnic identity is different than that of the dominant culture, and when a situation draws on a multitude of identities (such as in the case of Pat) or when others in the society define an individual as having unique nondominant identities (such as in Clay's case), one may be seen as having the status of an ethnic minority.

Primary and Secondary Crisis Intervention

This chapter describes a multicultural conceptual framework for guiding interventions with traumatized individuals. Relevant here is our belief that two principal opportunities for intervention exist that may occur at numerous points during an individual's life. The first opportunity occurs immediately after the traumatic events and involves helping the individual to begin dealing with the trauma and its implications at an occasion more proximal to that event. Intervening at this point may be critical for circumventing long-range adverse effects of trauma exposure (i.e., chronic posttraumatic stress disorder or PTSD).

As an example, the research literature both with war veterans and rape victims suggests that failing to intervene or provide a supportive environment may prolong or exacerbate PTSD-related symptoms (Barrett & Mizes, 1988; Coates, & Winston, 1983; Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; Lindenthal, Thomas, Claudwell, & Myers, 1971; Steiner & Neumann, 1978). Treatment provided at this juncture can be construed as *primary crisis intervention.* Critical incident stress debriefing (CISD; Mitchell, 1983) is an example of this form of crisis intervention.

When traumatized individuals request assistance in dealing with catastrophic experiences and their effects (e.g., sleep disturbance, isolation, hypervigilance, etc.), the conventional intervention involves supporting the victims by listening to their experiences and attempting to normalize their feelings. In some cases, this type of debriefing provides immediate relief. This brief cathartic treatment arrests some symptoms in those who are mildly or moderately affected by the events but may have little impact on those who are severely affected or who have a history of multiple traumas that remain unresolved (and for which related symptoms may have been reactivated by the recent event). Brief interventions of this type do not *typically* address the event's impact on an individual's unique sociocultural identities.

A second opportunity for intervention occurs later in the traumatized person's life during times of stress related to major turning points in life (e.g., divorce, death of loved ones, debilitating injuries, etc.). Because stressful life events can be expected to occur more frequently than traumatic events, this treatment condition may be the most frequent point of intervention. Treatment at this juncture can be construed as *secondary crisis intervention.* Inpatient treatment and longer-term outpatient therapy are prime examples of this type of crisis intervention. Both primary and secondary crisis interventions should include the cultural and identity considerations presented in this book and can follow the developmental and constructivist framework described in this chapter.

The Challenge of Treating PTSD in Ethnocultural Minorities

Ongoing treatment of the ethnic minority patient with PTSD presents an important and unique challenge to the mental health professional. To a significant degree, PTSD involves social avoidance and isolation (American Psychiatric Association, 1987; Wilson & Zigelbaum, 1986). The experience of PTSD often is described by patients as "feeling different from others" or "feeling like no one can really understand."

Individuals who grow up and live in a culture that is not congruent with aspects of their cultural identity often experience conflicts centered on belongingness, trust, and safety (Rodriguez, 1987). Furthermore, main-

stream American society, for example, also tends to undergo relatively rapid changes that can compound the significant challenges inherent in acculturating to that mainstream culture (see Young & Erickson, 1988).

Therefore, identity conflicts, compounded by traumatization, may enhance the severity or breadth of life problems experienced by the ethnic minority patient with PTSD (Brende & Parson, 1985). We agree with others that PTSD and ethnic minority status often interact to produce a heightened sense of isolation, disenfranchisement, and shame (Young & Erickson, 1988). The treating therapist is aided significantly by adopting a working model that addresses these multiple and interactive factors that contribute to subjective experience.

A Constructivist and Developmental Perspective

We approach the challenge of PTSD treatment with assumptions based on a constructivist and developmental framework. A *constructivist perspective* is founded on a belief in the proactive and self-organizing features of human experience. This perspective assumes that there is a form-giving, meaning-making part to each of us, so that for every waking moment of our lives an account is produced of who we are, what we are doing, and why we are doing it. Trauma stresses this meaning-making component to the extreme, at times leading to a rigidity and inflexible repetitiveness in the process of meaning-making. The trauma therapist needs to assume the constructive meaning-making function, thus aiding traumatized persons in their progress toward regaining the willingness and ability to be active, interpretive agents engaged in an exploratory process of meaning-making (Stewart, 1992).

A *developmental perspective* within the constructivist framework assumes that the self-organizing features of human knowing at any moment in the individual's life arise from the accumulation and, most important, the organization of experiences and interpretations of self and world across the entire life of the person (Mahoney, 1991; Carlsen, 1991). Such a developmentally informed constructivist view assumes that learning, knowing, and memory are phenomena that reflect the ongoing attempts of body and brain to reorganize continually action patterns and experience patterns—namely, prior learning—that are intimately related to highly dynamic, momentary experiencing.

Therefore, (a) the meaning of trauma or how trauma is construed varies widely from patient to patient, even within a single ethnic minority subgroup; (b) these meanings are accessible to the therapist through careful questioning, for example, understanding the developmental history of the patient, recognizing cultural factors and previous traumatization, and accessing the complex system of meaning networks associated with the trauma and posttrauma; and (c) posttraumatic symptoms often are ex-

pressed differently among different ethnic subgroups, and the symptoms exhibited may not be represented adequately in our diagnostic taxonomy.

A DEVELOPMENTAL MODEL FOR VIEWING TRAUMATIZATION

To understand the relationship between the traumatic event and its impact on the self, it is important to take an in-depth approach. This approach involves explicitly recognizing that trauma is a violation of self; a developmental meaning-based model can be applied to illuminate the ways in which the self has been violated. The developmental model encompasses the individual's *entire* life history, including the traumatic experiences. Using the model helps the therapist move beyond extinction of symptoms by helping the individual identify a full range of variables related to the origin of the symptoms and how these variables interact with the nature of the traumatic events.

The developmental model also provides the opportunity for the victim to identify personal coping mechanisms and their point of origin. These coping mechanisms may be initiated prior to, during, or immediately following the traumatic event; they may be healthy or they may be maladaptive. The evolution of how the individual perceives self prior to, during, and after the traumatic events and how these self-perceptions are overtly and covertly modified can assist the individual in meaningfully integrating the traumatic experience.

To implement the developmental model, it is essential that a preliminary psychosocial evaluation be completed to determine severity of posttraumatic stress, possible comorbidities, and sociocultural influences. Educating the victim about posttraumatic stress and its potential impact at this juncture sets the foundation for going beyond crisis management to understanding how the traumatic experiences have affected the victim's self-perception.

Assumptions About Self

We view traumatic experiences as violations of the self. We do not assume any particular theoretical position on whether a self exists and what that entails (cf. Dennett, 1978); rather, we understand that people, for whatever reason, believe that they have a self and that certain behavior is predictable from it. This self has several components, three of which are particularly important when dealing with issues of cross-cultural sensitivity.

First, there is the self as the accumulation of learned probabilities based on how the person has acted in the past. The self contains all of the expectations for self-action and anticipation about world responses, both

of which are weighted for their subjective importance. For example, I may expect that I will brush my teeth with my right hand but if I happen to use my left, it will not be significant for me or for those in my world. However, if I am usually a person who expresses anger verbally but I resort to physical violence when someone has angered me, a significant violation of my anticipations or expectations for my behavior will occur and will have more profound consequences for those in my world.

Second, there is the self as the idealization of what the person *ought* or *wants* to be. Such aspects of self may be historically based, as in the individual's idealization of a parent, but also they may be idealizations of a culturally transmitted group member ideal. Third, there are what we have come to call *self-fragments*. These also may be historically based expectations or idealizations, but they do not fit within a structured, multidimensional self-system. The person may have incorporated only one action directive as a cultural ideal without this fitting into a larger unifying framework.

In extreme situations in which expectations about how the world works fail, the anticipations of how a person will respond based on past experiences also may be invalidated. This may shift the person into attempting to behave like the ought-or-want-to-be ideal or may facilitate the person's reliance on fragmented behaviors. Stress occurs when the historically based anticipations and the idealized expectations conflict with the domain in which the person is acting. In particular, when no action can satisfy environmental demands and maintain all aspects of self, the person may feel extreme frustration. An example of this is provided via the following clinical vignette.

The Case of Alice

> Alice is a female Vietnam veteran of American Indian heritage. She dresses and is groomed in a way that does not express her Indian heritage, is married to a non-Indian, works in a large metropolitan area with a non-Indian population, and on coming into inpatient treatment did not avail herself of the counseling offered by a nurse specialist who has worked with Indian populations and is considered knowledgeable and approachable. Alice had stated on admission that she liked to go driving to deserted areas as a way to be alone and escape from her problems and that one day she would attempt suicide by driving off a high mountain. One of her early requests for a weekend pass was to go for a drive alone, on a holiday weekend when her family had decided not to visit her, along the mountain ridges not far from the hospital. This request was denied based on program policy; that is, it involved isolative behavior that was connected to stated suicidal ideation.

Alice became furious when her pass was denied, despite extensive discussion and feedback by staff and peers as to its apparent dysfunctional basis. The anger was excessive, including physical acting out by a normally mild-mannered woman, such that it appeared that some deeper, more meaningful issue had been activated. A culturally uninformed view might have assumed that the patient's plans for isolation, and possible suicide, had been thwarted and that alone explained the magnitude of the angry response. However, the clinician responded to the patient's consistency in speaking of the mountain as a *high place*, and wondered whether this term had a special meaning.

Initially, the patient denied any special meaning and said she just talked funny at times. However, by maintaining the focus on the meaning of going to a high place, the clinician, with the aid of the patient's peers, came to see that this action was part of an idealized, and to some degree, historically based anticipation derived from this apparently highly acculturated woman's Indian heritage.

The meaning structures that were discovered were as follows: "To fit in I must be a good Indian"; "To be a good Indian means giving up Indian ways"; "Going to a high place means being an Indian"; "Acting like an Indian means being cast out by the group (e. g., authorities, peers)"; "Therefore, going to the mountain means being cast out (loss of the non-Indian aspect)"; "Not going to a high place means feeling like I am dying (loss of the Indian aspect)."

The tension between these choices resulted in extreme frustration and, eventually, anger. Alice had hoped to be allowed to have a pass without discussion of its meaning to her—in other words, to be able to allow the Indian aspect to be present without threatening the non-Indian aspects of her self. However, addressing this dilemma in fact was an important key to the war-zone-related trauma work because in the war zone her Indianness had contributed to her being locked out of a compound because she was mistaken for a Vietnamese person.

A significant part of the healing for Alice arose from her being able to acknowledge both the Indian and the non-Indian anticipations, idealizations, and fragments of her self without being rejected by the staff or her non-Indian peers. The therapist's approach to this situation was informed by the constructivist–developmentalist therapy framework described earlier.

CULTURALLY SENSITIVE TREATMENT OF PTSD

To concretize the conceptual framework used at the Clinical Laboratory of the National Center for PTSD, we will outline a working model for culturally sensitive trauma treatment. In assessing a trauma victim across the lifespan, it is valuable to track the origin, development, and maintenance of the full range of self-components and of unique personal,

cultural, and social identifications. The individual's identity or set of identities is entwined, often intimately, in current expressions of PTSD and, thus, in its treatment. In the next section, we will provide guidelines for the elicitation of patients' unique constructions of their traumatic experiences and the cognitive–affective reconstructions that occur in treatment.

The Three-Way Mirror: A Therapy Heuristic

In our trauma work, we employ a heuristic, the Three-Way Mirror, for elucidating the complexities of multiple identities for the patient in therapy. This heuristic incorporates both constructivist and developmental tenets within a life narrative framework (Schafer, 1992; Stewart, 1992). The Three-Way Mirror (see Figure 1) provides a reflection of the individual's pretrauma, trauma, and posttrauma contexts. This visual aid is used also with patients to enhance their ability to understand the connections between the trauma and their multiple identifications.

The pretrauma panel represents the significant events prior to the individual's traumatic experiences and serves as a reference point. A number of important developmental themes and issues tend to emerge and can and should be addressed in the therapeutic context. Pretrauma themes include cultural practices, control, power, vulnerability, fear, relationships, intimacy, family, gender roles, sexuality, and religion. Within each of these themes the individual's beliefs, values, expectations, fears, and behaviors are explored and examined.

The middle panel focuses on the traumatic experience. In particular, specific processes are acknowledged, including: (a) attempts to suppress recollections of the event (e.g., numbing or denial) to escape from the stress and anxiety, (b) aggression as an attempt to gain control over the experience and emotion, and (c) survival coping mechanisms that can be interpreted as appropriate during the traumatic experience but can lead to maladaptive behavior.

The third panel represents the accumulation of one's life experiences, both before and during the traumatic events, that overtly or covertly influence how one functions and how one relates to new experiences. The three panels cover related issues discussed by Westermeyer (1987) in a six-point model for eliciting information about PTSD symptoms and the implications of these symptoms to the individual.

The Different Selves

Three important additional features of the three-way mirror are the experiential self, the observing self, and the new integrated self-representation. The experiential self represents the individual subjectively viewing and affectively processing life experiences both in isolated panels

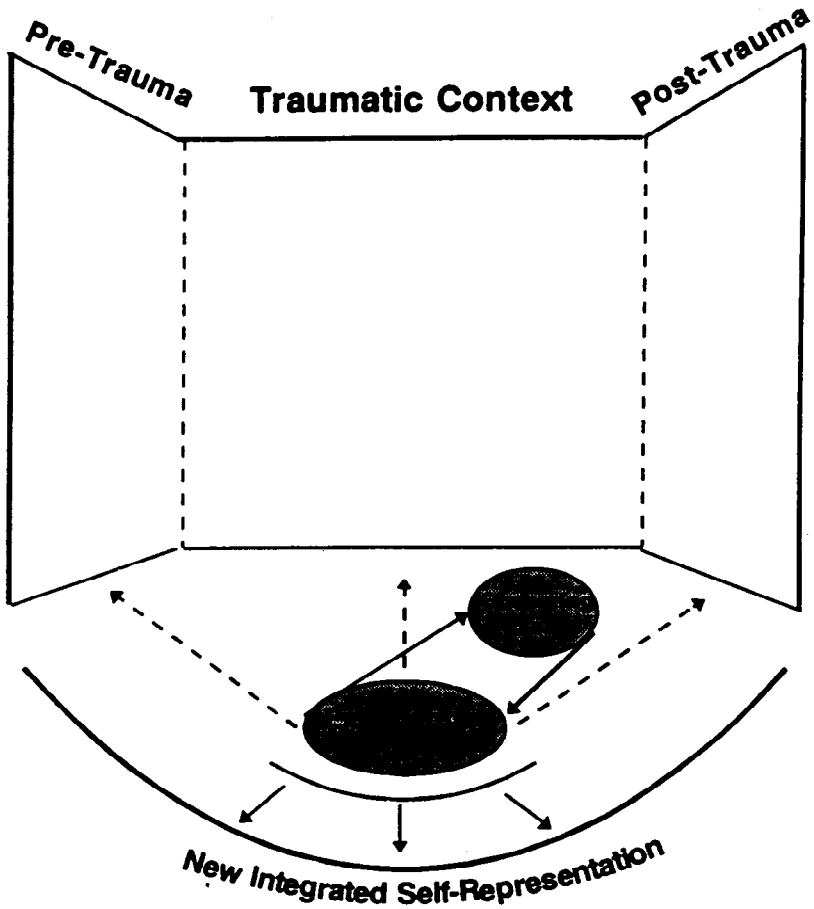

Figure 1. The three-way mirror is a therapy heuristic. The three panels of the mirror represent our developmental orientation. Affective and cognitive processing allows for a new, more intergrated self-representation.

and in total. The observing self represents the opportunity that arises for the individual to assess experiences and behaviors and their meanings objectively when some psychological distance from the emotional content of all the experiences represented in the panels, including the traumatic events, is obtained.

As the individual becomes able to move flexibly between the experiential and observing modes of processing, a new integrated self-representation can be developed. This new integrated self-representation represents the working through and incorporation of traumatic experiences

within a unified and continuous life narrative such that the individual experiences self-cohesion and some degree of meaningfulness and integration across life experiences.

New Self-Representations

The three-way mirror is a vehicle for helping the patient adopt a new, integrated self-representation. Through experiencing and observing one's life course, the patient makes connections and draws conclusions with respect to pretrauma, trauma, and posttrauma contexts, resulting in a reframing of the traumatic experiences and self. These stages of treatment are embedded in an overall program that is integrated and sequential in nature. Such integrative and sequential treatment is well suited to trauma work in general, but particularly when dealing with the complexities introduced in the treatment of trauma when multiple cultural selves (i.e., learned probabilities, idealizations, and fragments) are present (Loo, 1993).

Alice: An Application of the Treatment Model

To illustrate the three-way mirror, we will return to the case of Alice, the American Indian patient introduced earlier. As noted, she identified primarily with the dominant, Anglo-American culture. Psychosocial evaluations supported this impression. Alice exhibited moderate to severe PTSD symptoms with sporadic alcohol abuse. However, she had been employed continuously since the war, had been married for more than 20 years, and had raised two college-age children with whom she reportedly had a good relationship. Her relationship with her husband had become progressively more troubled, and at the time of her seeking intensive treatment, she feared that a divorce was imminent.

In the extensive assessment, completed during the first 2 weeks of her stay in the program, Alice did not refer to cultural practices associated with her Indian heritage. Conventional psychological assessment (e.g., the Clinician Administered PTSD Scale [CAPS; Blake et al., 1990] or the Structured Clinical Interview for *DSM–III–R* Patient Edition [SCID-R; Spitzer, Williams, Gibbon, & First, 1989]) may not elicit this information and, furthermore, it is not uncommon for individuals strongly identified with multiple cultures to assign different meanings to the symptoms in question (e.g., visions as part of religious practices as opposed to visual hallucinations).

However, when turning to the work of exploring themes, patterns, and self-conceptions across the lifespan, hints of a greater complexity of self-patterning and cultural affiliation begin to unfold. A useful tool for initiating exploration of the pretrauma self is the written pretrauma autobiography. A list of questions is provided that helps the individual begin

to reflect on the pretrauma environment and what expectations were developed around such issues as family; how to act and think given the individual's gender and religious and cultural practices; and ideas of self and self in relationships. Writing the autobiography begins the process of identifying the learned probabilities of self, the idealizations of how the person *ought* or *wants* to be, and at times can provide hints to fragments of self.

In the case of Alice, the writing of the pretrauma autobiography clarified the cultural split that had been introduced early in her life and offered explanation for her determined attempt to present only the non-Indian side in the institutional context of the hospital. She had been raised on a reservation within a large, extended, loving family, with clear culturally congruent gender role differentiation.

At about 8 years of age, it was decided that Alice should go to Catholic boarding school. At that school, the split and accompanying tension was established. She was made to feel that Indian ways were "evil" uncivilized, and un-Christian, and she was punished by practices of rejection and condemnation whenever she allowed some Indian aspect of herself to surface. Thus, that which was "good" was non-Indian; that which was spiritually and interpersonally rich was "bad." As a result, Alice developed fear that others might see core aspects of her self; thus, to show Indian aspects of self became entwined with the danger of being harmed (e.g., rejected and abandoned).

During the trauma focus work, it became clear that this split was operative in the war zone. Newly arrived in country, she found herself outside the compound without identification and was denied entry because she looked like the enemy. Thus, as in her youth, being identified as *different* equated with being dangerous and bad.

Throughout her time in Vietnam, she appears to have engaged with these two selves, at times flaunting her identification with the enemy and rebelling against military constraints, in what were occasionally quite dangerous activities. These behaviors can be seen as instances of denial and of coping by reconstruing reality. Thus, we see a core theme established as critical for self-definition in childhood is central to understanding trauma-related behavior (i.e., the second panel of the Three-Way Mirror).

During the latter period of treatment, Alice participated in a group that focused on the entire lifespan, particularly on identifying reenactments in the posttrauma period (Stewart, 1993). Such reenactments can be a result of the dysfunctional extension of trauma-related coping mechanisms or the desire to redo the trauma with a different conclusion. It is in the work of this period that the themes that are continuous across the lifespan are identified and the subtle and not so subtle modifications of these themes via experience, particularly traumatic experiences, are reflected.

In a graph of her posttrauma life, in which she traced the emotional and functional ups and downs of this period with the use of icons to represent recurrent influences (e.g., trees represent periods of spiritual reconnection with high places), the two selves generally entwined and hovered in an emotionally neutral plane of the graph. However, for a period of 3 years she had allowed herself to work on a reservation and to live once again following Indian ways. At this point the two selves separated, with clearly differentiated emotional tones associated with each. The happy, joyful self was the Indian one; the sad, restless self was the other. The association of the Indian self with badness continued to some degree because her residence on the reservation far from home adversely affected her nuclear, Anglo family.

Despite this, she felt that this brief period post-Vietnam was the only time that she had had moments of happiness, calm, and contentment. She could assume an observing stance with regard to these two selves and could talk about the different anticipations and idealizations of each and how they often were in conflict. This focused her healing and recovery on finding a resolution so that she could more readily embrace and integrate both self-components.

RELATED MULTICULTURAL PERSPECTIVES ON TRAUMA AND RECOVERY

Catherall (1989) provided a valuable reference for the clinical implications of multiculturalism and PTSD treatment. Two central clinical issues were conceptualized: (a) conflicts in self-integration and (b) the loss of self-cohesion. In conflicts in self-integration the victim is intact characterologically but cannot assimilate or tolerate the feelings associated with the trauma. In such cases, the victim's self-identity is not a primary clinical issue. However, in cases of the loss of self-cohesion, characterized by the misalignment and dysynchrony between victims and their social environment, the psychological impact is more severe and results in social withdrawal, feelings of mistrust and alienation, identity disturbance, and interpersonal difficulties.

These symptoms amount to a *disorder of the multicultural self.* Here, as in the case examples of Pat, Clay, and Alice, the clinical issues and therapeutic tasks involving multicultural identity become essential to facilitating the victim's capacity to reconstitute a sense of self. The therapeutic process facilitates an integration between the victim's perception of self (i.e., the self as a personal construct comprised of propositions related to beliefs, values, and expectations), with the cognitive–emotional meaning assigned to the events and to other significant psychosocial events or developments in the victim's life history.

Hiley-Young (1992) proposed a framework for differentiating between subtypes of trauma reactivation as a guide to client treatment-matching that is applicable to the disorder of the multicultural self. In cases that involve a disorder of self, treatment initially emphasizes process rather than content and, initially, at helping the patient to feel understood—first about current stressors and then about other significant life events. An account of early memories of childhood and adolescence is obtained.

A pretrauma review serves to encourage the patient's sense of control, in addition to providing valuable information. This review takes into account moment-to-moment events during earlier significant events and afterward. When appropriate, information regarding stress response syndromes is interjected. The effect of orchestrating information giving with encouraging emotional ventilation bolsters the patient's tolerance for increasing amounts of traumatic-linked affect and its assimilation.

Therapeutic structures and procedures necessary for treating the traumatized self include the provision of a *holding environment* to facilitate self-cohesion (e.g., clear therapeutic contract, appointment times). Concerted attention to the therapeutic relationship and to relevant cultural, contextual cues is necessary for the adequate development of rapport (Parson, 1985; Pina, 1985).

In addition, therapy must help examine the relationship between the patient's behavior and feelings (e.g., apathy, hopelessness, identity diffusion), facilitate the patient's perceptual differentiation between current and past threats, facilitate cognitive restructuring of events, teach problem solving and stress management skills as they apply to current problems, provide information regarding stress–response syndromes, and link the individual to other trauma survivors and their organizations. A treatment provider who attributes the individual's dysfunction as precipitated solely by the trauma and trauma-related stressors likely would err by ignoring the individual's multicultural identity issues.

Most PTSD treatments aim to enable the traumatized individual to become as self-sufficient as possible. Thus, these treatments *empower* the individual to lead a productive and fulfilled life. Empowered individuals have learned adaptive and generalizable skills with which to manage symptoms, emotions, and the exigencies of life. These skills might involve managing distress from PTSD symptoms or negotiating the cultural barriers to trauma recovery (e.g., recovery from a psychiatric breakdown during battle by individuals from relatively stoic cultures or from rape in cultures in which discussion of sexual activities is discouraged). Empowerment of this type provides the individual with the capabilities to manage PTSD and related symptoms and resume a normal life.

The developmental–constructivist model described in this chapter was developed as an empowering approach for application in cross-cultural PTSD treatment. In the model viewing individuals as being a product of

a single cultural context is seen as being too narrow and that a multicultural perspective is considerably more helpful. We introduce the Three-Way Mirror as a method of integrating lifespan data and as a formal intervention technique (and visual aid) to be used with the patient. We also encourage working through reactivation issues as well as uncovering layers of meaning structures.

CONCLUSION

Several conclusions can be reached from the information presented in this chapter. It is clear that clinicians and researchers working with traumatized individuals need to be cognizant of and sensitive to the multicultural influences that have direct implications for a range of identities. Graduate and continuing education should include exposure to multicultural issues; supervised training in cross-cultural treatment may be an essential complement to classroom exposure (Westermeyer, 1989). Each PTSD patient should be evaluated and treated with these identifications in mind. In clinical work, adopting a constructivist framework that includes a developmental perspective (e.g., the Three-Way Mirror) allows for greater consideration of an individual's multiculturality.

Ethnicity and trauma in America are likely to overlap increasingly in the future. Evidence for this increase can be found in the well publicized stories about U.S. immigrants from around the world and the efforts made to make more culture-fair and culture-sensitive our employment practices and access to education and health care services. In this evolving context, the challenges for PTSD treatment are formidable.

Marsella, Chemtob, and Hamada (1990), for example, cited three broad areas of ethnocentrism and bias in current psychiatric practice: (a) inappropriate standards of normality and abnormality; (b) lack of knowledge about the expression, course, diagnosis, assessment, and outcome of psychiatric disorders; and (c) the use of inappropriate therapy procedures, including pharmacotherapy (i.e., some medications work differently for different cultural groups). Marsella, Friedman, and Spain (see chapter 4, this volume) also point out the limitations in much of the cross-cultural research on PTSD and the need to conduct research that considers the ethnocultural context of the patient. Advances in each of these areas are critical for the future of cross-cultural PTSD treatment.

We recommend that information about the interplay of ethnicity and PTSD treatment be obtained and integrated into research as well as practice. Development of measurement tools, for example, that simultaneously assess different roots to a complex identity, is needed. It also remains unclear what patient–treatment matches are best for various ethnic groups. Perhaps different techniques from different schools of therapy may produce

a better fit with a given ethnic group. In the same way, how members of one cultural group tend to view mental health treatment and treatment providers is likely to influence the determination of optimal patient–treatment matching (Westermeyer, 1989).

A second recommendation can be made at the organizational level. Agencies and institutions that provide services to PTSD patients should develop multicultural initiatives. Included here are initiatives pertaining to service delivery, such as those that will enhance interagency communication and maximize the availability of mental health services and treatment and service providers to cultural groups located in geographically remote areas (e.g., American Indians who reside on reservations and Pacific Islanders who live away from urban areas). Other initiatives include developing theories and treatments for PTSD that take into account cultural pluralism, increasingly becoming the rule rather than exception in American society.

In this chapter, we have outlined a model for addressing multiculturality in PTSD treatment. Although we have experienced success following this model, it is clear to us that PTSD professionals have only begun to recognize the considerable influence of culture on trauma recovery. As with most constructs, recognition is a first and necessary step toward fuller understanding. It is our hope that with our growing awareness of cultural influences will come more efficacious treatment for this multifaceted and multicultural disorder.

REFERENCES

American Psychiatric Association. (1987). *Diagnostic and statistical mnual, of mental disorders* (3rd ed., rev.). Washington, DC: Author.

Barrett, T. W., & Mizes, J. S. (1988). Combat level and social support in the development of posttraumatic stress disorder in Vietnam veterans. *Behavior Modifications, 12*, 100–115.

Berry, J. W. (1990). Psychology of acculturation. In J. J. Berman (Ed.), *Cross-cultural perspectives* (pp. 201–234). Lincoln: University of Nebraska Press.

Blake, D. D., Weathers, F., Nagy, L. M., Kaloupek, D. G., Klauminzer, G., Charney, D. S., & Keane, T. M. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS-1. *The Behavior Therapist, 13*, 187–188.

Boehlein, J. K. (1987). Culture and society in post-traumatic stress disorder: Implications for psychotherapy. *American Journal of Psychotherapy, 41*(4), 519–530.

Brende, J. O., & Parson, E. R. (1985). Special veteran groups: Women and the ethnic minorities. In J. O. Brende & E. R. Parson (Eds.), *Vietnam veterans: The road to recovery* (pp. 125–165). New York Plenum Press.

Carlsen, M. B. (1991). *Creative aging: A meaning-making perspective.* New York: Norton.

Catherall, D. R. (1989). Differentiating intervention strategies for primary and secondary trauma in post-traumatic stress disorder: The example of Vietnam veterans. *Journal of Traumatic Stress, 2,* 289–304.

Coates, D., & Winston, T. (1983). Counteracting the deviance of depression: Peer support groups for victims. *Journal of Social Issues, 39,* 169–194.

Dennett, D. C. (1978). *Brainstorms: Philosophical essays on mind and psychology.* Montgomery, VT: Bradford Books.

Goode, W. J. (1960). A theory of role strain. *American Sociological Review, 25,* 483–496.

Gordon, M. (1964). *Assimilation in American life: The role of race, religion, and national origins.* New York: Oxford University Press.

Gove, W., & Tudor, J. (1973). Adult sex roles and mental illness. *American Journal of Sociology, 78,* 812–835.

Hiley-Young, B. (1992). Trauma reactivation and treatment: Integrated case examples. *Journal of Traumatic Stress, 5*(4), 545–555.

Keane, T. M., Scott, O. N., Chavoya, G. A., Lamparski, D. M., & Fairbank, J. A. (1985). Social support in Vietnam veterans with post-traumatic stress disorder: A comparative analysis. *Journal of Consulting and Clinical Psychology, 53,* 95–102.

Lindenthal, J., Thomas, J., Claudwell, S., & Myers, J. K. (1971). Psychological status and the perception of primary and secondary support from the social milieu in time of crisis. *Journal of Nervous & Mental Disease, 153,* 92–98.

Loo, C. M. (1993). An integrative-sequential treatment model for posttraumatic stress disorder: A case study of the Japanese American internment and redress. *Clinical Psychology Review, 13,* 89–117.

Madsen, W. (1964). The Mexican-Americans of South Texas. G. Spindler & L. Spindler (Eds.), *Case studies in cultural anthropology* [Monograph series]). New York: Holt, Reinhart, & Winston.

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy.* New York: Basic Books.

Marsella, A. J., Chemtob, C., & Hamada, R. (1990). Ethnocultural aspects of PTSD in Vietnam War veterans. *National Center for PTSD Clinical Newsletter, 1*(1), 3–4.

Marsella, A. J., Friedman, M., & Spain, E. H. (1993). Ethnocultural aspects of PTSD. In J. Oldham, M. Riba, & A. Tasman (Eds.) *Review of psychiatry* (pp. 157–181). Washington, DC: American Psychiatric Press.

Mitchell, J. T. (1983). When disaster strikes: The critical incident stress debriefing. *Journal of Emergency Medical Services, 8,* 36–39.

Oetting, G. R., & Beauvais, L. L. (1990). Orthogonal cultural identification theory: The cultural identification of minority adolescents. *International Journal of the Addictions, 25,* 655–685.

Parson, E. R. (1985). The intercultural setting: Encountering Black Viet Nam veterans. In S. M. Sonnenberg, A. S. Blank, Jr., & J. A. Talbot, (Eds.), *The trauma of war: Stress and recovery in Vietnam veterans* (pp. 363–387). Washington, DC: American Psychiatric Press.

Pearlin, L. I. (1983). Role strains and personal stress. In H. B. Kaplan (Ed.), *Psychosocial stress: Trends in theory and research* (pp. 3–32). New York: Academic Press.

Pina, G., III. (1985). Diagnosis and treatment of post-traumatic stress disorder in Hispanic Vietnam veterans. In S. M. Sonenberg, A. S. Blank, Jr., & J. A. Talbot (Eds.), *The trauma of war: Stress and recovery in Vietnam veterans* (pp. 389–402). Washington, DC: American Psychiatric Press.

Rodriguez, O. (1987). *Hispanics and human services: Help-seeking in the inner city.* New York: Hispanic Research Center, Fordham University, Bronx.

Sarbin, T. (1954). Role theory. In G. Lindzey (Ed.), *Handbook of social psychology Vol. 1* (pp. 223–255). Reading, MA: Addison-Wesley.

Schafer, R. (1992). *Retelling a life: Narration and dialogue in psychoanalysis.* New York: Basic Books.

Spitzer, R. L., Williams, J. B., Gibbon, M., & First, M. B. (1989). *Structured Clinical Interview for DSM III(R)—Patient edition (SCID-P).* New York: Biometrics Research Department, New York State Psychiatric Institute.

Steiner, M., & Neumann, M. (1978). Traumatic neurosis and social support in the Yom Kippur War returnees. *Military Medicine, 143,* 866–868.

Stewart, J. (1992, July). *Reconstruction of self: Lifespan-oriented group psychotherapy.* Paper presented at the Fifth Conference of the North American Personal Construct Network, University of Washington, Seattle.

Stewart, J. (1993, July). *Retraumatization issues in the assessment of trauma survivors.* Workshop presented at the Continuing Education Course "Women Veterans Health and Issues of Sexual Trauma," Department of Veterans Affairs, Baltimore.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different* (2nd ed.). New York: Wiley.

Westermeyer, J. (1989). Cross-cultural care for PTSD: Research, training, and service needs for the future. *Journal of Traumatic Stress, 2*(4), 515–536.

Wilson, J., & Zigelbaum, S. (1986). PTSD and the disposition to criminal behavior. In C. Figley (Ed.), *Trauma and its wake: Traumatic stress theory, research, and intervention* (Vol. II, pp. 305–322). New York: Brunner/Mazel.

Young, M. B., & Erickson, C. A. (1988). Cultural impediments to recovery: PTSD in contemporary America. *Journal of Traumatic Stress, 1*(4), 431–443.